Application for Dental Licensure by Credentials

GEORGIA BOARD OF DENTISTRY
237 Coliseum Drive
MACON, GA 31217
Phone (478) 207-2440
www.sos.ga.gov/plb/dentistry

Please read the instructions carefully and be familiar with the laws and rules governing the practice of dentistry in the State of Georgia. Visit the board's web site for information: **http://www.sos. ga.gov/plb/dentistry**.

IMPORTANT

The Board cannot process incomplete applications. If any item is missing, incomplete or incorrect, your application cannot be reviewed by the Board. Please review this application before submission to ensure that all information and documentation is complete and correct. Incomplete applications result in delayed processing. Incomplete applications are void after two years.

The $3000. application fee may be paid by personal checks or money order made payable to the order of Georgia Board of Dentistry. APPLICATION FEES ARE NON-REFUNDABLE AND NON-TRANSERABLE. Checks returned for insufficient funds will be assessed a service charge pursuant to O.C.G.A.§ 16-9-20.

1. **NOTARIZED APPLICATION:** accompanied by the appropriate fee. Your application will not be processed unless the fee and all supporting documents are received. If licensure is granted, the license will be required to be renewed by the last day of December in ODD numbered years, regardless of when you were originally licensed. The licensure process could take up to a minimum of **30 days** after submission of a completed application. Plan your application time accordingly.

2. **APPLICABLE LAWS AND RULES:** O.C.G.A § 43-11-41 and Board Rule 150-7-.04 give the specific requirements for licensure by credentials. These laws and rules may be found on the board's website at www.sos.ga.gov/plb/dentistry.

3. **LICENSE VERIFICATION: Official license verification** for **every** dental license **ever** held. Each verification must indicate the date of licensure, the licensure status (active, inactive, expired, revoked, etc.) standing of license, any disciplinary charges made against you by the licensing board and the result of these actions. The applicant must provide a copy of the formal complaint/pleading, outcomes, and a personal written explanation for each instance of discipline. You should call each state board about fees for these services. The verification must be submitted with your application IN THE

ORIGINAL SEALED ENVELOPE FROM THE BOARD OF EACH STATE, and must be dated within four months of Board receipt of your application.

4. **DEGREE TRANSCRIPT** which documents graduation with a D.D.S. or D.M.D. degree from a dental school which is accredited by the American Dental Association Commission on Dental Education. The transcript must be IN THE ORIGINAL SEALED ENVELOPE FROM THE COLLEGE. Graduates from non-accredited schools please see Board Rule 150-3-.04 and O.C.G.A.§ 43-11-40(a)(1)(A) and (B).

5. **NATIONAL BOARD SCORES** from the ADA Joint Commission on National Dental examinations. The ADA (1-800-621-8099) will send a copy of National Board scores to state licensure boards only. If you ask the ADA to send our board a copy of your National Board scores, so indicate in your application packet. **DO NOT SUBMIT THE NATIONAL BOARD CERTIFICATE. NATIONAL BOARD SCORES MUST COME DIRECTLY FROM THE NATIONAL BOARD TO OUR OFFICE.**

6. **CLINICAL LICENSING EXAMINATION:** ***Certification*** **that the applicant has successfully completed** with a passing score in each section, a clinical licensing examination in general dentistry conducted by a regional or state testing agency that meets the following criteria:
    a. Anonymity between candidate and examiners.
    b. Pyschometrically valid procedures for standardization and calibration of the examiners.
    c. A post examination analysis of the scoring for single examination aberrations.

    Such verification shall state that the examination included clinical testing on live patients in the following areas:
    a. Periodontal clinical abilities testing.
    b. Completion of at least two of the following four areas:
        a. Class II Amalgam preparation and finish
        b. Cast Gold preparation and finish, Class II inlay, onlay, partial or full coverage crown
        c. Class II Composite preparation and finish
        d. Class III Composite preparation and finish

    Such verification shall also include clinical testing on mannequin or model in the following areas:
    a. Endodontic clinical abilities testing access opening and root canal fill
    b. Prosthodontic clinical abilities testing of partial denture, full denture and implant case planning.

Additional clinical abilities testing modules successfully completed will be considered as substitutes where appropriate for the above requirements if those modules test a similar skill set. **If the examination completed did not require testing in the above listed modules, the application will be considered on an individual basis.**

IMPORTANT: Clinical scores MUST be broken down by section, with a score for each of these sections. All candidates must have taken and passed a clinical examination with a score of 75 or greater on all sections of the examination. The clinical examination MUST be Board approved.

7. **JURISPRUDENCE EXAMINATION:** The examination must be downloaded from the web-site. The laws and rules are also on our website. The fee for this examination is $25.00, payable to the order of **Georgia Board of Dentistry.** Law examination fees are non-refundable. **A score of 75 or higher is considered a passing score.**

8. **NATIONAL PRACTITIONER DATA BANK:** To obtain a self query from the NPDB-HIPDB, please visit www.npdb-hipdb.com or call the Customer Service Center at 1-800-767-6732.

If the National Practitioner Data Bank(NPDB) report provides any disciplinary action, certified copies of any pending or final disciplinary actions or malpractice actions against applicant must be submitted. All applicants must submit a NPDB report along with the completed application. The NPDB report must be dated within four months of the submission of the application. The ONLY applicants exempt from the requirement of NPDB report submission are those applicants within 6 months of dental school graduation and/or those who have never been issued a dental license in any state or U.S. territory. The NPDB report must be received in the ORIGINAL SEALED ENVELOPE FROM NPDB. Applicants who have disciplinary or malpractice case(s) (open & closed) will be considered for licensure on a case- by-case basis, after receipt of all required application materials. For each case, the applicant must submit:
1) a copy of the formal complaint pleadings filed by the plaintiff/complainant or State Regulatory Agency,
2) a copy of the final action, disposition, or settlement,
3) a personal explanation of the disciplinary action or the malpractice claim, and
4) any further information requested by the Board in separate communications.

9. **COPY OF COURT DOCUEMNTS OR AFFIDAVITS** explaining any discrepancies of the applicant's name if documents submitted bear different name(s).[i.e. marriage certificate, divorce decree, legal name change]

10. **CPR:** A photocopy of current CPR certification in compliance with Board Rule 150-3-.08.

11. **DEA REGISTRATION:** Verification of applicant's status with the federal Drug Enforcement Administration (DEA), from the DEA, even if applicant is not currently registered with the DEA.

12. **EMPLOYMENT AFFIDAVIT: An affidavit from the applicant stating for the five years** immediately preceding application:
(A) the dates and locations where the applicant has practiced dentistry; and
(B) that the applicant has been in full time clinical practice of a minimum of 1000 hours per year in the hands on treatment of patients. Training programs do not qualify as full time clinical practice. **Please note that the practice requirement cannot be waived as it is required by law.**

13. **MALPRACTICE QUESTIONNAIRE:** Complete one for each suit and attach the necessary documentation. (If not applicable, write N/A on the form sign, date, and return with application).

ALL dental licensure by credential applications MUST BE APPROVED by the Board.

Upon receipt of the license, the applicant by credentials must establish active practice in this state within two years of receiving such license or the license shall be automatically revoked.

Relocation: If you relocate during the time that your application is being processed, you **must** notify the Board of your new address in writing by fax (866) 888-1308 or mail. This will enable you to receive Board correspondence.

SUBMIT YOUR COMPLETED APPLICATION PACKET TO

Georgia Board of Dentistry
237 Coliseum Drive
Macon, Georgia 31217

Listing of States accepted for Licensure by Credentials Dental and Dental Hygiene

Alabama
Alaska
Arkansas
Arizona
Colorado
Connecticut
Delaware
Idaho
Illinois
Indiana
Iowa
Kansas
Kentucky
Louisiana
Maine
Maryland
Massachusetts
Michigan
Minnesota
Mississippi
Missouri
Montana
Nevada
New Hampshire
**New York
North Carolina
North Dakota
Ohio
Oklahoma
Oregon
Pennsylvania
Rhode Island
South Carolina
South Dakota
Tennessee
Texas
Utah
Vermont
Virgin Islands
Virginia ***Acceptance of hygienists ONLY***
Washington
West Virginia
Wisconsin
Wyoming

*Information Pending

**Yes, provided completion of a clinical licensing examination and not PGY1.

States not accepted for Licensure by Credentials – Dental and Dental Hygiene***

California
District of Columbia
Florida
Hawaii
Nebraska
New Jersey
New Mexico
Puerto Rico
Virginia

***Please refer to Georgia Rule 150-7-.04 and O.C.G.A.§ 43-11-41 for dentists, and Georgia Rule 150-7-.05 and O.C.G.A.§ 43-11-71.1 for dental hygienists**

Please note all application fees are non-refundable and non-transferable.

This list is subject to change and will be updated on an as needed basis.

Revised 5/6/09

Do Not Write In This Section:
Receipt#: _____
Amount: _____
Applicant #: _____
Initials/Date: _____

Board Name: **Georgia Board of Dentistry**
Address: **237 Coliseum Drive**
Address: **Macon, GA 31217-3858**
Telephone #: **(478) 207-2440**
Fax #: **(866) 888-1308**
Website: **www.sos.ga.gov/plb/dentistry**

Application For: Dental Licensure by Credentials
Obtained By Method – Credentials - $3,000 Non-refundable/Non-transferable application fee.
Checks returned for non-sufficient funds will be assessed a $40 service charge pursuant to O.C.G.A.§ 16-9-20

DISABILITY- If you have a disability and may require an accommodation, you must contact the Board to obtain the REQUEST FOR DISABILITY ACCOMMODATIONS GUIDELINES.
VETERANS PREFERENCE POINTS- Veterans may be eligible for special benefits in testing. For more information, contact the Board office. **Submit copy of DD-214 with your application.**

Part I: Personal Information

1. Name:_____
Last First Middle Maiden

Name as shown on examination records or transcripts (if different)
_____
Last First Middle Maiden

2. Social Security Number***:** _____- _____-_____ **3.** Date of Birth:_____

3. If your mailing address is a P.O. Box, you must provide a physical address:
_____
(Street) (Apt. #) (City/State/Zip Code)
If you are granted a license, your name, mailing address and license number are public information.

4. Mailing Address: _____
(Street) (Apt. #) (City/State/Zip Code)

5. E-Mail Address:_____

6. Telephone #: Home: ( )_____ Work ( )_____ Other ( )_____

7. ___ I am a U.S. Citizen ___ **I am not a U. S. citizen**
but am a qualified alien under the federal Immigration and Naturalization act, and I am lawfully present in the United States**. ** Submit attached checklist form with documentation**, and provide required documentation

8. Military Service: _____ Dates of Service: _____
Honorable/Dishonorable Discharge: _____

***This information is authorized to be obtained and disclosed to state and federal agencies pursuant to O.C.G.A. §19-11-1 and O.C.G.A. §20-3-295, 42 U.S.C.A. §551 and 20 U.S.C.A. §1001. It may also be disclosed to the National Practitioner's Databank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB) or other licensing boards, or other regulatory agencies for license tracking purposes. **Submit copy of Registration Card.**

Part II: Professional Education

9. Highest Degree Earned: ____Doctorate _____Post-doctorate

10. Name/Address of undergraduate college/university:

_____

a. Dates Attended: _____ c. Graduation Date: _____
b. Major: _____ d. Degree(s) Earned: _____

11. Name/Address of Dental School/University**:**_____

a. Dates Attended: _____ c. Graduation Date: _____
b. Major: _____ d. Degree(s) Earned: _____

12. Name/Address of Post-Graduate School/Hospital (if applicable):_____

a. Type of Training: _____ b. Dates Attended: _____

13. National Board Information:
I understand that it is my responsibility to see that a copy of my scores be mailed from the Joint Commission on National Dental Examinations directly to the Board. For your convenience, the number is: 1-800-621-8099.

_____
Signature of Applicant

14. National Practitioners Data Bank/Healthcare Integrity and Protection Data Bank
The Georgia Board of Dentistry requires all candidates for licensure to query the **NPDB/HIPDB** before licensure will be considered. You may contact the NPDB/HIPDB by calling: 1-800-767-6732 or by submitting your query online at: www.NPDB.com. When you receive the RESPONSE from the NPDB/HIPDB please forward the information to the Board office along with your completed application. **If you are a recent graduate (within the past six months) and not licensed in any other state, you are exempt from this requirement.**

Part III:

If yes to any of the following questions you must attach a full written explanation pertaining to that particular question.

16. Was your pre-dental education or dental education interrupted, other than the usual vacation periods? ☐ Yes ☐ No

17. Do you presently have any contagious or infectious disease? ☐ Yes ☐ No

18. Have you ever been charged with driving under the influence of alcohol or drugs? ☐ Yes ☐ No

19. Have you ever had a formal complaint filed against you with any dental society, association, hospital, or dental board? ☐ Yes ☐ No

20. Has any state licensing board revoked or suspended your certificate/license, or taken other disciplinary action? ☐ Yes ☐ No

21. Have you ever been denied a DEA registration number or been issued a restricted DEA registration? ☐ Yes ☐ No

22. Have you ever voluntarily surrendered a dental license, a controlled substances registration, or DEA registration? ☐ Yes ☐ No

23. Have you ever had any malpractice suits filed against you? ☐ Yes ☐ No

24. Have you ever been denied participation in, or suspended from the Medicaid or Medicare benefit program? ☐ Yes ☐ No

25. Have you ever been denied issuance of or, pursuant to disciplinary proceedings, refused renewal of a license by any board or agency in Georgia or any other state? ☐ Yes ☐ No

26. Have you ever been denied the privilege of taking an examination before any Dental Board or licensing authority? ☐ Yes ☐ No

27. Have you ever failed an examination required of any Dental Board or other licensing authority? ☐ Yes ☐ No

28. Have you failed a portion of any clinical examination, CRDTS, NERB, ADEX, SRTA, WREB, CITA, or any other regional or state clinical examination? ☐Yes ☐ No **If yes, give dates (list regional and/or state if applicable)**

_____ _____ _____ _____

If you have failed this exam three (3) or more times please request an exam history form CRDTS, NERB, ADEX, SRTA, WERB, CITA, or any other regional or state board.

29. Have you ever been refused any privilege of prescribing controlled substances, or had any prescribing privileges of controlled suspended or revoked? ☐ Yes ☐ No

30. Have you ever been refused, or suspended from membership in a dental society, or association, or hospital staff? ☐ Yes ☐ No

31. Have you ever personally used narcotics or alcohol excessively or have you ever undergone treatment for addiction to alcohol or other controlled substances or habit forming substances? ☐ Yes ☐ No

32. Have you ever been summoned, arrested, taken into custody, indicted, convicted or tried for, or charged with, or pled guilty to, or pled, nolo contender to, a violation of any law or ordinance or the commission of any felony or misdemeanor (excluding minor traffic violations), (DWI & DUI are **not** minor traffic violations), or have you been requested to appear before a prosecuting attorney or investigative agency in any matter? ☐ Yes ☐ No

(Although a conviction may have been expunged from the records by order of court, it nevertheless must be disclosed in your answer to this question). If yes, for **each** occurrence furnish a written statement giving the complete facts in your own words, including in such statement the date, name and nature of the offense, the name and locality of the court, and the disposition of each such matter. **You must attach the court disposition.**

33. Are there any other facts not disclosed by your answers which may have a bearing on your fitness or eligibility to practice dentistry in Georgia and which should be placed at the disposal or brought to the attention of the State Board of Dentistry? ☐ Yes ☐ No

34. Out of State Licensure Certification(s):

List all states which you have been issued a license to practice dentistry: (active, inactive, revoked, suspended, expired, lapsed etc.) You should have each state listed send an official letter of licensure verification/certification. **See instruction sheet for details**.

STATE	DATE OF LICENSURE	LICENSE STATUS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

35. References: Listed below are two references that I have supplied with the proper form that was included in my application packet.

I understand that it is <u>my responsibility</u> to see that these <u>forms are returned</u>. I certify these references are not related to me, nor are they connected with any dental college I attended.

Name_____ Name_____

Address_____ Address_____

City, State, Zip_____ City, State, Zip_____

Occupation _____ Occupation _____

Revised 9/14/09

OFFICE OF SECRETARY OF STATE
PROFESSIONAL LICENSING BOARDS DIVISION
GEORGIA BOARD OF DENTISTRY
237 Coliseum Drive
Macon, Georgia 31217
(478) 207-2440

CONSENT FORM

I hereby authorize **The GEORGIA BOARD DENTISTRY** to receive any criminal history record information pertaining to me which may be in the files of any state or local criminal justice agency in Georgia.

_____

(Applicant's Full Name – Printed)

_____

_____

Physical Address (P.O. Boxes **NOT** Accepted)

_____ _____ _____ _____

Sex Race Date of Birth Social Security Number

Place of Birth (City/State): _____

Aliases or Maiden Name: _____

Please check any applicable licensure provisions below that apply to the individuals you will be practicing your profession on:

_____ Working with mentally disabled
_____ Working with the elderly or in elder care services
_____ Working with children

PLEASE COMPLETE THE FOLLOWING:

I, _____
(print name)
give consent to the Georgia Board of Dentistry to perform periodic criminal background checks for the duration of my active licensure status with this state.

_____ _____

(Signature of Applicant) (Date)

Part IV:

36. AFFIDAVIT OF APPLICATION

I acknowledge and state that I have read the Application and Instructions that accompanied this application and I have answered all questions in compliance with these instructions. I acknowledge that it is my responsibility to read and become familiar with the Dental Practice Act and the Board Rules.

I further state that by submitting this application for a license to practice dentistry/dental hygiene in the State of Georgia, I hereby authorize and consent to have an investigation made as to the moral character, professional reputation and fitness for the practice of dentistry/ dental hygiene. I agree to give any further information in which may be required in reference to my past record. I understand that I will not receive a copy of the report or know its contents and I further understand that the contents of the investigative report will be privileged unless determined otherwise by the Board of Court Order.

I hereby authorize the Georgia Board of Dentistry to receive any criminal history record pertaining to me, which may be in the files of any state or local criminal justice agency in Georgia or any other State or Territory.

I authorize and request every person, hospital, clinic, community, governmental agency (local, state, federal or foreign), court, association, institution, or other organization having control of any documents, records and other information pertaining to me, to furnish to the Georgia Board of Dentistry any information, including documents, records, regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Georgia Board of Dentistry or any of its agents or representatives to inspect and make copies of such documents, records and other information, in connection with this application, subsequent licensure or practice thereunder.

I hereby release, discharge and exonerate the Georgia Board of Dentistry, it's agents or representatives, and any person so furnishing information, from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records or other information or the investigation made by the Georgia Board of Dentistry. I authorize the Georgia Board of Dentistry to release information, material, documents, orders or the like relating to me or to this application to any other State or Territory of the United States or Province of Canada, a law enforcement agency, a hospital or other appropriate agencies as determined by the Board.

I, the undersigned, do hereby affirm under penalty of perjury that all statements made and information contained in this application are true and correct to the best of my knowledge and belief. Further, I consent to a thorough investigation of my employment record and other information that may be necessary to verify my qualifications to practice. I understand that any final disciplinary action that may ever be taken against my license, if it is granted, would be provided to a national disciplinary reporting system and that my Social Security number would be a part of that report.

This is to certify that the foregoing information is true and correct to the best of my knowledge.

_____

Signature of Applicant

(PHOTOGRAPH)

Date _____ Attach recent passport type photograph

_____

(Print Name Above)

County_____State_____

being duly sworn, says that he/she is the person who executed the above application for license to practice dentistry/dental hygiene in the State of Georgia; and that all the statements herein contained are true in every respect and that the attached photo is a true photo of the applicant.

_____ **Notary Public**

<u>Notary:</u> Do not notarize this section unless photograph is attached.

Sworn to and subscribed before me this _____ day of _____, _____.

(SEAL) My Commission Expires_____

Part V: MALPRACTICE QUESTIONNAIRE

_____

Name of Dentist Business Telephone

_____

Address City, State, ZIP

MALPRACTICE CHARGES/ALLEGATIONS: Include name of patient, age, sex, date of occurrence and location (include address).

_____

_____

_____

_____

_____

_____

List names of other dentist and/or physicians:_____

_____

_____

DISPOSITION: ☐ Pending ☐ Settled If settled, provide the following information:

Settlement Date_____ Total Settlement Amount_____

Amount Attributable to you: _____ ☐ In Court ☐ Out of Court

The Board requires that you furnish documentation of the above information directly from the insurance company or attorney. Such documentation should include plaintiff's complaint, settlement agreement, and/or court order.

_____ _____

Signature Date

COMPLETE ONE QUESTIONNAIRE ON EACH MALPRACTICE SUIT - YOU MAY DUPLICATE THIS FORM.

If not, applicable, please write (N/A), sign and return with completed application.

Part VI: **STATE LICENSURE CERTIFICATION**

TO THE APPLICANT: *Please complete the top section of this form and mail to each state in which you are now or have been licensed to practice dentistry. This form may be reproduced as necessary.*

TO: _____ Board of Dentistry

I am applying for licensure and the Georgia Board requires that your Board complete this form in order that my application for licensure may be considered. By signing this form, I am giving my consent to the release of any information, favorable or otherwise, for its review in considering me for licensure.

My license Number _____ was issued by your Board on _____ on the basis of ( )State Board Exam, ( ) Reciprocity/Endorsement, ( ) National Board, ( ) Credentials, ( ) other _____.

_____

Applicant's Full Name (print or type) Address

_____ _____

Signature City State ZIP

This section to be completed by an official of the above referenced licensing board. Please return this form directly to the applicant in a sealed envelope.

Dental License Number _____ to practice dentistry in the State of

_____ was issued on _____ to _____.

Licensee

Is license current and in good standing? ____ Yes ____ No*

Has any disciplinary action ever been taken against this license?

_____Yes* _____No , ***If yes, please attach disciplinary documents.**

*** Please provide complete details, including copies of any documents.***

_____ _____

Signature Date

_____

Title (**BOARD SEAL)**

_____

Licensing Board

Part VII

GEORGIA BOARD OF DENTISTRY

AFFIDAVIT

DENTAL LICENSURE BY CREDENTIALS

This form must be completed, signed, notarized and returned with the application packet.

For the five years immediately preceding my application for licensure by credentials, I have practiced at the following locations:

Location (COMPLETE ADDRESS)	**Dates of Employment**

I have been in full time clinical practice of a minimum of 1,000 hours per year in the hands–on treatment of patients. I understand that training programs do not qualify as full time clinical practice.

_____
Signature

_____
Date

Affirmed to and subscribed before me this _____ day of _____, 20_____.

(Official Seal) _____
Notary Public

My commission expires _____, 20_____.

GEORGIA BOARD OF DENTISTRY
237 Coliseum Drive
Macon, Georgia 31208
(478) 207-2440

(You may duplicate this form)

TO THE REFERENCE: The person listed below is applying for licensure as a dentist in the State of Georgia. The applicant is required to furnish satisfactory evidence that he/she is qualified to practice professional dentistry. You have been given this form as one who knows the applicant well and can attest to his/her character, ability, reputation, and professional attainments.

The statements you provide must be from personal knowledge only, and should be made with full realization of the responsibility toward the public involved. You should answer fully, carefully, and with the utmost frankness.

Be assured that the information you furnish will be treated as **strictly confidential.** Please return your recommendation directly to the applicant. **RETURN TO APPLICANT IN A SEALED ENVELOPE.**

NAME OF APPLICANT _____

FROM _____
Reference Full Name (Daytime telephone # including area code)

_____
Address

_____
City Zip Code

1. Are you a licensed dentist? ___**Yes** _____ **No** If yes, what state(s)? _____

If no, what is your present profession? _____

2. How long have you known the applicant? ___ Years. Are your related? _____

3. In what capacity have you known him/her _____

_____

4. Do you know anything reflecting adversely on the applicant's integrity or general good character?
_____ **Yes** _____ **No** **If yes, give details on a separate page.**

5. Do you feel that this applicant is qualified to have responsibility of a dental office? _____ **Yes**
_____ **No** **If no, give details on a separate page.**

6. Would you feel comfortable going to this person for your dental needs? _____ **Yes** _____ **No**
If no, give details on a separate page.

7. What is the applicant's character, reputation, and standing in the community?

_____

_____

_____

NAME OF APPLICANT _____

FROM_____

Additional Comments _____

_____

_____

The undersigned certifies that the above statements, to the best of his/her knowledge and belief, are correct.

_____ _____ _____

Signature Title Date

DOCUMENTATION TO DETERMINE QUALIFIED ALIEN STATUS

Please check the box which applies to your status. You must provide copies of the required documentation as an attachment to this form.

Alien Lawfully Admitted for Permanent Residence:
_____ - INS Form I-551 (Alien Registration Receipt Card, commonly known as a "green card"
_____ - Unexpired Temporary I-551 stamp in foreign passport or on INS Form I-94

Asylee:
_____ - INS Form I-94 annotated with stamp showing admission under §208 of the INA
_____ - INS Form I-688B (Employment Authorization Card) annotated "27a.12(a) (5)"
_____ - INS Form I-766 (Employment Authorization Document) annotated "A5"
_____ - Grant letter from the asylum office of INS
_____ - Order of an immigration judge granting asylum

Refugee:
_____ - INS Form I-94 annotated with stamp showing admission under §207 of the INA
_____ - INS Form I-688B (Employment Authorization Card) annotated "274a.12 (a) (3)
_____ - INS Form I-766 (Employment Authorization Document) annotated "A3"
_____ - INS Form I-571 (Refugee Travel Document)

Alien Paroled Into the U.S. for at Least One Year:
_____ - INS Form I-94 with stamp showing admission for at least one year under §212(d) (5) of the INA

Alien Whose Deportation or Removal Was Withheld:
_____ - INS Form I-688B (Employment Authorization Card) annotated "274a.12 (a) (10)
_____ - INS Form I-766 (Employment Authorization Document) annotated "A10"
_____ - Order from an immigration judge showing deportation withheld under §241 (b) (3) of the INA

Alien Granted Conditional Entry:
____ - INS Form I-94 with stamp showing admission under §203 (a) (7) of the INA
_____ - INS Form I-688B (Employment Authorization Card) annotated "274a.12 (1) (3)
_____ - INS Form I-766 (Employment Authorization Document) annotated "A3"

Cuban/Haitian Entrant:
_____ - INS Form I-551 (Alien Registration Receipt Card, commonly known as a "green card") with the code CU6, CU7, or CH6
_____ - Unexpired temporary I-551 stamp in foreign passport or on INS Form I-94 with the code CU6 or CU7
_____ - INS Form I-94 with stamp showing parole as "Cuba/Haitian Entrant" under §212(d) (5) of the INA

Alien Who Has Been Battered or Subjected to Extreme Cruelty:
_____ - INS petition and appropriate supporting documentation

_____
Name of Applicant